Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases

Introduction

This study of Long-Term Strategies for Community Placement and Alternatives to Institutions for Mental Diseases (IMDs) was conducted, under contract, for the California State Department of Mental Health (DMH). The Study Team consisted of Beverly Abbott, J. R. Elpers, Pat Jordan and Joan Meisel. Two consultants worked with the project team, Darlene Prettyman and Alice Washington; they offered additional expertise in family member, consumer and cultural competence issues.

The Study was designed to analyze and evaluate California's current long-term care system for persons with serious mental illness, specifically the use of IMD and SH (SH) resources.

The Study has taken place during a time in which counties have felt significant pressure to reduce the use of IMDs and SHs. Some of these pressures include the following:

- Budgetary constraints have focused attention on these services since they are among the most costly components of a county's system of care.

- The growing emphasis on recovery by both professionals and consumers has highlighted concerns about the appropriateness of this level of care for assisting the recovery process.

- Implementation of the Olmstead decision puts the spotlight on this most restrictive of mental health settings.

Study Methodology

The Study consisted of three phases.

- ***Background and Basic Information Gathering.*** This phase included interviews with counties and collection and analysis of statewide IMD utilization data. It was designed to create a framework for understanding how IMDs fit into counties' systems of care and for identifying hypotheses for what accounts for varying use patterns by county. The results of this phase were presented in a preliminary report produced in December 2003. This

report highlighted some of the differences in the patterns of usage of IMD/SH resources among counties (Appendix A).

- ***In-depth Information Gathering in Six Counties.*** This phase of the Study explored in greater depth the factors that influence varying levels of usage of IMD/SHs in six counties. The counties were selected to reflect the diversity in the state and include both high and low users of IMD/SHs. Four primary sources of information on these counties were analyzed for this report:

  - ***County Site Visits.*** The Study Team conducted a one or two day site visit to each county in the Spring of 2004. Interviews were conducted with county mental health staff representing management, the long-term care unit (the unit responsible for IMD and SH use), the emergency and crisis unit, the acute hospital unit, and the community system. Also interviewed were representatives of private and public acute hospitals, the Public Guardian's Office, the Patient Advocate, families, clients in IMDs, IMD facilities, residential programs, and board and care (B/C) operators. A follow-up call was made to each county in late 2004 or early 2005 to obtain important updates relevant to IMD/SH utilization.

  - ***Tracking Study***. Clients admitted to IMDs or SHs in each county were tracked for approximately one year. The sample sizes were 10 in County F, 30 in County A and County D, 60 in County C and County E, and 132 in County B. The total number of clients was 315 and the county Study enrollment period ranged from a low of about three months in County C to over nine months in County A to a full14 months for County F. Information was collected on a three-month basis until the clients were discharged. Follow-up information in the community was collected on as many clients as possible, but obtaining accurate and comprehensive follow-up information was problematic.

  - ***Long-Stay Clients.*** Four of the five large counties collected information on a selected sample of their clients who had been in an IMD/SH for at least 18 months. The counties reported they had 599 such clients in IMD/SHs in the fall of 2004. Data were gathered on 193 of these clients.

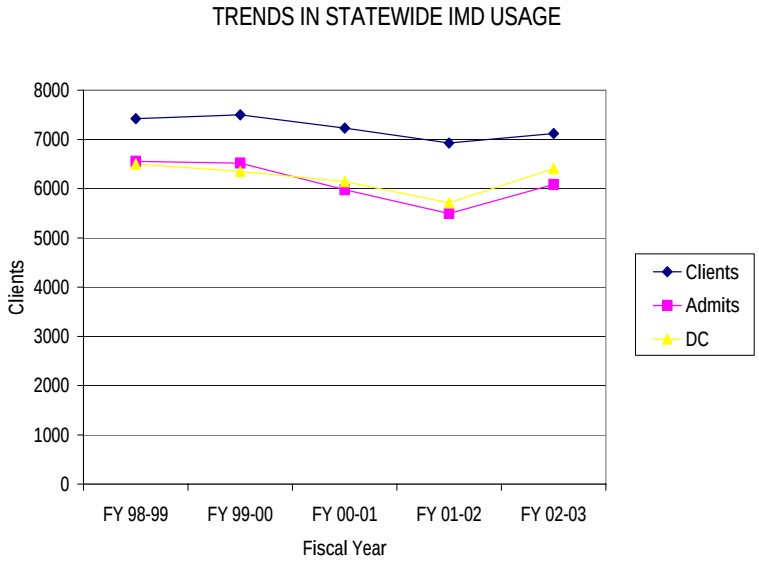
  - ***IMD Site Visits.*** The psychiatrist member of the Study Team, occasionally accompanied by another Study Team member, visited nine IMDs. The visits consisted of an interview with the facility administrator and program leaders, a walk-through of the facility, and a review of at least five charts of clients (selected randomly) who had been in residence for at least one year. The chart reviews emphasized the treatment and discharge planning, medication prescription patterns (judged by the general principles embodied in the Cal-MAP and T-MAP protocols), cultural sensitivity and recovery vision.

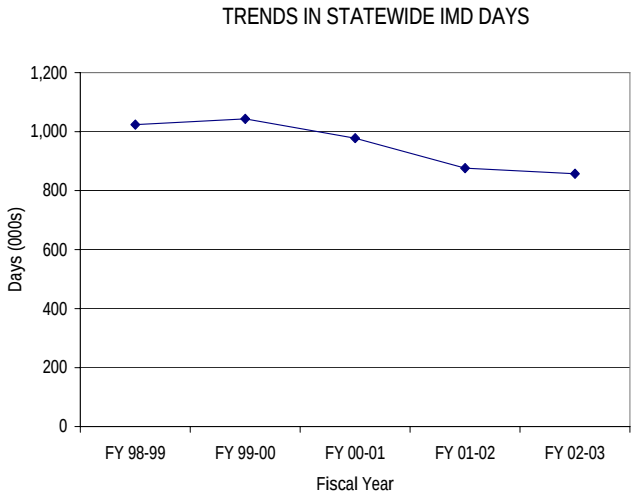
- ***Analysis and Development of Recommendations and Promising Practices.*** This phase of the Study, culminating in this report, uses the statewide information from phase one, the empirical information from the client-level data and the qualitative understanding of the unique circumstances in each of the six study counties, to analyze and evaluate California's current long-term care system for persons with serious mental illness, specifically the use of IMD and SH resources. In addition this phase identifies strategies and promising practices and makes recommendations to assist the state and counties in achieving more appropriate usage and lower utilization of IMD/SHs.

Statewide Context

State data[i] suggests a fairly steady number of IMD clients over a five year period but a gradual decrease in the number of IMD days.

The charts below show the trends in the number of IMD clients and the number of IMD days statewide from FY 98-99 to FY 02-03.





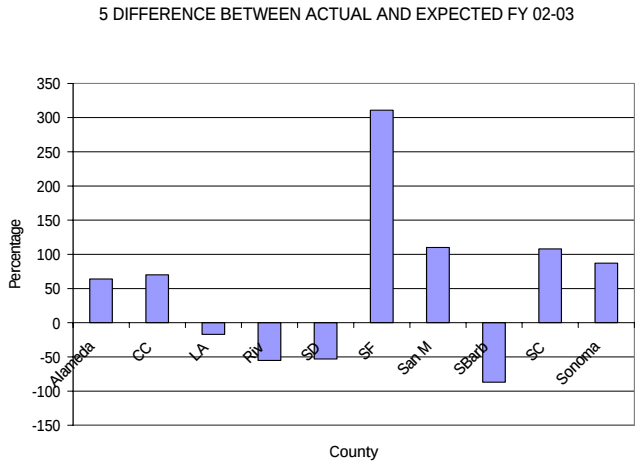
These trends mask wide variations among the counties in their trends over time. Examples of the variations by county can be found in Appendix F.

There are sizable differences among counties in their rates of use of IMD beds.

To get a measure of the relative usage of IMD beds we used the newly created relative ratings of counties used for the Mental Health Services Act (MHSA) distribution of funds for Community Services and Supports Plans. This measure was developed to be a measure of relative need adjusted by available resources[1] We multiplied the percentage weighting of each county according to this formula by the total number of statewide IMD days resulting in an "expected" number of days if each county's use of IMD beds was proportional to its relative need/resources. We compared this "expected" number of days

[1] DMH Letter 05-02, available at www.dmh.ca.gov/MHSA.

with the "actual" number of days. Those counties who have more actual than expected days are higher relative users of beds while those with fewer actual than expected days are lower relative users. The chart below shows the percentage over or under expected of some counties, selected to show the range of variation.



Ideally we would like to identify an optimal level of usage, but we are not yet able to do so.

While there are these clear pressures to reduce usage, neither this study nor any other of which we are familiar is able to provide evidence for the optimal level of usage of non-acute locked 24-hour care. Ideally this evidence will come from the accumulation of decisions made by individual clients in partnership with their treatment staff about what is the most appropriate care for them at various points in their recovery. But such decisions can be meaningful only when there is a full complement of alternative community services to IMDs/SHs.

Since counties do not yet have such full complements of community services, nor do we yet have a fully implemented client-directed recovery-oriented approach to care, the best we can do is to explore how the IMD/SHs are being used within county systems of care and provide information that can be used by counties to review and change their system of care to ensure that IMD and SHs are used only when other community-based alternatives are not available, and then for only so long as necessary.

Six County Study

The Study includes an in-depth analysis of IMD use in the six study counties, and identifies factors that influence decisions about the use of IMDs and SHs.

The Study has examined data and policies regarding admissions, the care that people receive while they are in IMD placements, factors that influence discharge and transitions from IMDs to the community, factors that influence whether people are discharged or remain in locked care and predictors of disposition. Each of these areas comprises a

section of this report. We have included the data for County F in only some of the tables because its small size makes comparisons with the other counties sometimes potentially misleading. For each section we describe the overall factors first and then the differences among the Study counties.

The study of SH usage was more limited than that for IMDs. We explored how counties used the SH as differentiated from IMDs and gathered information about clients admitted to the SH during the Study period and clients who were in the Long-Stay Study. Counties use the SH for clients who have the greatest severity of violent behaviors, who have not done well in other placements including IMDs and/or for individuals who have specialized physical or medical needs that complicate their mental illness.

There is an Appendix for the Phase One Report, and for each of the major sources of data as well one for data from the State DMH Management Information System (MIS).

- ***Appendix A: Phase One Report, December 2003***
- ***Appendix B: Narrative County Reports.*** There is a report of information from the site visits for each of six counties.
- ***Appendix C: Tracking Study***
- ***Appendix D: Long-Stay Client Study***
- ***Appendix E: IMD Site Visits.*** There is a brief discussion of each facility followed by a summary of overall findings.
- ***Appendix F: Statewide Data.*** This data comes from the state Client Data System (CDS) and Client Services Information (CSI) systems and is used mostly to indicate major trends and county variations.

Admissions/Gatekeeping

OVERALL FINDINGS

Indicators of behavior and functioning on Tracking Study clients at admission to an IMD confirm that they have significant current disabling issues.

Counties were asked to indicate for clients entering the Tracking Study as new admits to an IMD whether certain significant behaviors had occurred within the last 30 days. The four most serious were: repeated suicidal ideation with expressed intent, recent homicidal ideation with expressed intent, repeated episodes of violence towards self, and repeated episodes of violence towards others. Overall, 48% of the clients had at least one of these four conditions reported as occurring within the last 30 days. The most frequent condition was violence towards others (31%) followed by suicidal (16%), homicidal (15%), and violence towards self (12%).Clients in the two youngest age categories were more likely to exhibit one of these serious conditions: 76% for those under 21 and 67% for those between 21 and 30. This could reflect a greater prevalence of these behaviors within this age group or perhaps a greater reluctance to admit younger clients to IMDs unless they had more serious risk conditions.

Counties completed a Multnomah Community Assessment Scale (MCAS) (Appendix G) on each client admitted to an IMD. Norms are available for the MCAS (by age/sex categories) based on a sample of clients in Multnomah, Oregon, described by the scale developers as follows: "clients were enrolled in community support units of Community Mental Health Centers (CMHC). This enrollment implies that they suffer from a major mental illness (i.e. schizophrenia or bipolar disorder), have been hospitalized in the recent past or are at risk of hospitalization, and suffer from social role impairment in several areas." A deficit of this instrument is that norms are not available on ethnically diverse populations. This instrument was selected because a large, diverse Study county was using it.

We would expect that the clients in the Tracking Study would be similar to these clients, but that their scores at the time of intake into an IMD would be lower than the norms of the Multnomah clients because of the more acute nature of their disorder at time of their entry into the IMD. This is in fact the case for most of the population subgroups except for the males aged 35-50 and the females over age 50, which are similar to MCAS norms.

Average MCAS Scores for Tracking Study Clients
Compared to Normed Multnomah Clients by Age/Gender

Age/Gender	Tracking Study Clients	MCAS Norms
Males 18-34	49.7 (N=65)	52
Females 18-34	47.4 (N=27)	55
Males 35-50	51.9 (N=77)	52
Females 35-50	47.8 (N=40)	56
Males 51+	47.9 (N=35)	52
Females 51+	52.2 (N=25)	52

Subsets of clients have other issues at intake which require attention either before and/or during episodes in an IMD.

The table below indicates the percentage of clients who at intake to the IMD were rated as being homeless, having a significant substance abuse problem, significant health issues, known history of trauma or abuse, or having a minor child. The mental health systems of most counties are increasing their attention to the issues of homelessness and substance abuse, and we comment below on the perceived attention to medical problems while clients are in residence in IMDs. We suspect that less attention is being paid to the issues of trauma and abuse during treatment and that attention to the role of clients as parents may also receive less attention than may be warranted.

Conditions/Situations at Admission to IMD

Condition/Situation	%
Last living situation: Homeless/shelter	29%
Substance abuse a factor in triggering this episode	25%
"Moderate" to "marked/extreme" health impairment (on MCAS)[ii]	23%
Known history of trauma or abuse	9%
Have a minor child	10%

Additionally, almost two-thirds (62%) of the clients are rated as having a history of medications "non-compliance". The percentage rated with some criminal justice involvement at intake (9%) may be lower than actual, but indicates the importance of relationships with the criminal as well as civil part of the justice system. (See Appendix C for more details.)

About one-quarter of the clients lived with their family of origin prior to the episode leading to the IMD admission.

The percentage of clients who were living with their family of origin was 33% in County A, 30% in County B and 28% in County C. This suggests the opportunity for outreach programs for families which might prevent an acute episode resulting in an IMD admission. Families should be provided with the immediate support they need to avoid an IMD admission and to find less restrictive alternatives to institutionalization when their loved one is experiencing a crisis or relapse.

All of the Study counties had a centralized process for authorizing admissions to IMDs, but the results of these processes vary.

As indicated in our Phase I Report, almost all counties now utilize a centralized process to control access to IMDs – as did all of the case study counties. While the function is common there are major differences in its implementation. This next section presents the differences in admission rates as well as some of the factors which we think help explain these differences.

COUNTY DIFFERENCES

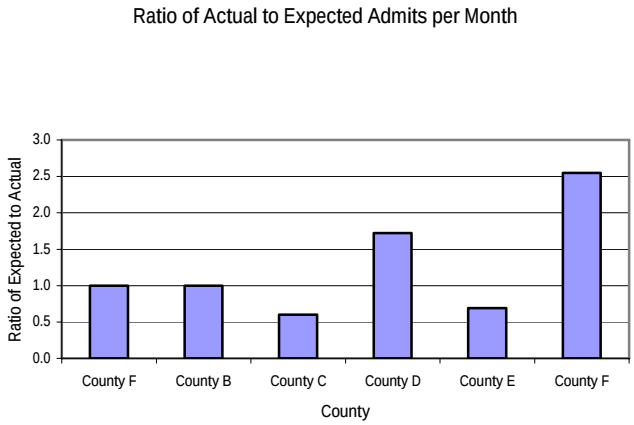
Two of the Study counties have admission rates that are two to three time higher than the other three.

We used a number of ways of assessing admission rates since there is no evidence-based standard for what is optimal. We calculated the number of admissions into the Tracking Study per month for each of the five study counties and divided this by two figures, the total adult population in the county and the total adult population under 200% of poverty. In terms of rates per overall population County C and County E are two to three times the rates of County B and County D; these differences are even greater when compared to population under 200% of poverty.

IMD Admissions to Tracking Study Compared to Population by County

	County F	County A	County B	County C	County D	County E
Tracking Study						
Admits per month/adult pop	6	8	4	11	5	13
Admits per month/adults < 200% poverty	14	20	12	47	16	86

To obtain another measure of "relative need/resources" which might explain some of the differences we utilized the recently developed relative county index which will be used to distribute the Community Services and Supports funding under the MHSA. We used County A as the index county since it was in the middle of the five counties on the two rates using population. We calculated an "expected" number of admissions to IMDs per month (compared to County A) based on the "relative need/resource" index and compared that to the actual admissions per month from the Tracking Study. On this measure (with County A automatically having a value of one with expected equal to actual) County C was over 1 ½ times and County E over 2 ½ times its expected with County B, and County D almost half expected. Again – these figures are used merely to illustrate the differences among the counties without any indication of which may be the most appropriate level.



Civil commitment rates are consistent with the above, with County A and County D having relatively low and OR and SC relatively high rates.

In the Preliminary Report we noted our growing awareness of the critical interplay between IMD/SH utilization and the civil commitment philosophy and process at the county level and indicated that we would pursue this issue in our case studies. The table below shows the number of temporary and permanent conservatorships in relationship to the number of SSI disability clients in the five counties, and shows the same patterns as the IMD/SH admissions.

Rates of Conservatorship Use Per Disability SSI Recipients by County[iii]

	County F	County A	County B	County C	County D	County E
Temporary Conservatorships/SSI Recipients	0	0	0.8	2.6	0.3	1.5
Permanent Conservatorships/SSI Recipients	1.3	0.3	2.3	4.8	0.7	4.3

The data about the civil commitment status of clients in the Tracking Study adds other information to the picture. The table below shows the percentage of each county's Tracking Study clients with a particular civil commitment status at entry into the IMD. For example, 41% of County A's 29 clients (12 clients) were on a 180-day dangerousness certification, 55% (16 clients) were on conservatorship, and 3% (one client) was on a temporary conservatorship. The "Total" column is simply the sum of all the clients in the Tracking Study for whom we have this information (305 clients).[2]

Civil Commitment Status at Time of Admit to IMD by County[3]

	County A (N=29)	County B (N=132)	County C (N=59)	County D (N=29)	County E (N=56)	*Total (N=305)*
180 Day Dangerousness	41%	0	5%	0	0	*5%*
Conservatorship	55%	80%	17%	55%	70%	*61%*
T-Con	3%	20%	76%	45%	30%	*33%*
Voluntary	0	0	2%	0	0	*<1%*
	100%	100%	100%	100%	100%	*100%*

- County A stands out as the only county to use the 180-day certification for dangerousness which is initiated by the acute hospital unit. A psychiatrist in the Department of Mental Health screens clients who then have the right to all LPS procedures and protections, including filing a writ to request a court hearing. A recent (within last week) documented instance of hurting some one or threatening someone is required for the psychiatrist to consider the recommendation of a 180-day dangerousness certification. A separate program has been instituted to serve these clients in the IMD.

- The high percentage of clients on T-cons when admitted to the IMDs in County C results from a current Public Defender policy of aggressively challenging the establishment of permanent conservatorships.[4] As a

[2] The Total column does not have a precise meaning. It does not reflect any statewide figures. Because the samples for each county were not drawn to be proportionally representative of the total cases from the study counties the figure is not strictly representative of the totals for these counties.
[3] A 30-day extension for Grave Disability was not used by any of the case study counties.
[4] County C Site Visit Report, Appendix B, page 6.

consequence there is a significant (at least three month) wait for jury trials with a resulting extension of the time during which clients are on T-cons.

- The high percentage of permanent conservatorships in County B results from a policy which essentially requires such a status prior to admittance to an IMD. The courts will not accept the testimony of the IMD physicians in the conservatorship proceedings and so clients must remain in acute units on T-cons until a permanent conservatorship has been established.

Data from the Tracking Study shows not only the interrelationships between IMD admissions and LPS policies and procedures but also the impacts and consequences of these on acute care lengths of stay (LOS).

The table below shows the mean, median and categories of days for the acute care LOS for clients who were admitted to an IMD.

LOS Mean, Median and Percent in LOS Categories in Acute Facilities by County

	County A (N=20/25)	County B (N=53/93)	County C (N=58/58)	County D (N=9/26)	County E (N=47/56)	*Total (N=187/259)*
Mean (days)	26	80	41	18	16	*43*
Median (days)	25	72	38	18	11	*31*
<2 weeks	5%	0	3%	44%	64%	*20%*
2-4 weeks	65%	11%	22%	44%	28%	*26%*
4-6 weeks	20%	8%	41%	11%	6%	*19%*
6-8 weeks	10%	13%	14%	0	0	*9%*
8-10 weeks	0	13%	10%	0	0	*7%*
>10 weeks	0	54%	8%	0	2%	*19%*
	100%	100%	100%	100%	100%	*100%*

- County B stands out with average acute lengths of stay prior to IMD placement which much longer than the other counties in part because of the lower level of IMD beds available and because of the requirements for the establishment of a permanent conservatorship before entry into an IMD.

- Almost all the admissions to IMDs in County E (86%) came from the county hospital which has increased its efforts to reduce Administrative Days and is thus attempting to move clients through the acute system more quickly.

- In County C, clients back-up in the private acute hospitals, which are the primary referral source for clients into the in-county IMDs which serve as short-term stabilization units for the county.

- County D and County A appear to process their clients through the acute system within 4 to 6 weeks.

Usage is also affected by the orientation of the county's leadership about the use of IMD/SH resources.

As noted in the Introduction, because of constrained resources all counties have been forced to examine the role of IMD/SH care because of its high cost. These budgetary pressures have been the primary influence leading to initiatives to control utilization. The two low usage counties (County A and County D) have also had strong clinical support for the closer scrutiny of IMD/SH usage. This confluence of cost and clinical concerns appears to lead to a more integrated system-wide approach to the question of appropriate usage of IMD/SHs. But it should be noted that obtaining a consensus among all the relevant participants did not come easily in either county; both struggled over time to get everyone on the same page. Two other counties (B and E) appear to control usage through departmental direction and the budgeting of fewer beds.

- **County A:** The impetus for stricter control of access to IMD beds came from a very active patient right's unit, which, in pursuit of concerns about the quality of care in IMD/SHs, began over a decade ago to question the standards for grave disability for conservatorship determinations. The consequence has been a system-wide restrictive view about conservatorship and IMD/SH placements. While the mental health LTC unit has the final say on IMD admissions, an interdisciplinary team (IDT) (with membership from the acute unit, the appropriate adult SOC rehabilitation team, family members, the conservator's office, and the patient rights advocate) considers clients referred for IMD placement. These IDT meetings have evolved from a contentious bickering to a relatively smooth process in which all parties are in general agreement about standards for placement in an IMD. The use of standardized forms has helped the process run more smoothly. However concerns have been expressed by some families that conservatorships are too hard to get when families think they are needed.

- **County D:** The impetus for strict control in County D comes from the adoption of a strong underlying philosophical commitment to place clients in locked facilities only as a last resort; this commitment was made within an overall implementation of a recovery orientation actively pursued by the LTC unit. Admission to an IMD occurs only after a face-to-face interview with a member of the LTC team. They ask clients where they want to go and try to accommodate those requests. They are comfortable with supporting placements in the community even if the placement might "fail".

- **County B**: The combination of the requirement that clients already be on conservatorship before they enter an IMD and the shortage of available beds results in acute hospital stays in this county which are exceedingly long with a large proportion of administrative days. This leads the hospitals to discharge many clients that might otherwise have entered an IMD. County B maintains tight control over all its IMD/SH resources, tracking census on a daily basis.

- **County E**: In 2000, when County E began its efforts to reduce its IMD usage it transferred the control over IMD admissions from the county hospital to a centralized unit located within MH which was given strong direction and support from the new department director and the deputy director. Prior to this shift as many as one-quarter of the clients in the acute setting were referred for IMD admission. The morale of the centralized unit is clearly enhanced by having the back-up and first-hand involvement of top DMH management.

- **County C:** The centralized unit in County C basically processes paperwork. While there is a dedicated staff in this county's centralized unit they do not take an active role in controlling access to IMDs. Most of their IMD admissions come from the private hospitals in the community who make referrals to the unit. After a paper review of the case the unit transfers the paperwork to an IMD to pursue the admission process. Additionally, some clients are admitted directly to the IMD at one of the contract facilities from the acute-level care provided in another part of that facility, with notice being provided to the centralized unit of the admission. There has been no pressure from the top management to alter the level of admissions to IMDs.

MCAS scores differ somewhat by county, although the implications of this are not always clear.

The table below indicates the mean and median MCAS scores on each client at intake to the IMD as well as the percentages in the high, medium, and low categories utilized by the test originators.

MCAS Scores at Intake by County

	County A (N=30)	County B (N=130)	County C (N=57)	County D (N=29)	County E (N=25)	Total (N=271)
Low	43%	26%	68%	72%	16%	41%
Medium	57%	58%	25%	28%	60%	48%
High	0	15%	7%	0	24%	11%
Mean	47	53	45	42	56	50
Median	49	53	43	43	58	50

These scores are generally consistent with what we would predict

- County D, with the tightest standard, has the lowest MCAS scores.
- County E, while trying to reduce its level of IMD usage still has a relatively high proportion of admissions so that higher MCAS scores should not be surprising.
- County B has relatively higher MCAS scores because the MCAS is filled out at the time of admission to the IMD after the client has had a fairly long time period in an acute care setting within which to stabilize and improve.

The relatively lower MCAS scores for County C remain somewhat of a mystery given their generally higher IMD admission rates and moderately long lengths of stay in acute facilities. This might relate to the lack of a county hospital in this county.

Care and Monitoring During Stay in an IMD

Information for this section comes from a variety of sources.

As part of the Study we explored the quality of care in the IMDs, but a formal assessment of the quality of care in IMD/SHs was not a formal part of the Study design. The information provided below was collected to better help us understand the overall picture of IMD care and is not meant to be a definitive quality review.

As noted in the Study methodology, we gathered information about the actual and perceived quality of care in IMDs from the following sources:

- IMD site visits by the psychiatrist member of the Study Team to nine IMDs. These visits and chart reviews provide information about the overall policies of the facilities, including their orientation to recovery principles; medication practices; treatment and discharge planning; and some sense of family involvement and cultural competence.

- A form was completed on clients in the Long-Stay Study which asked about treatment plan goals, medications, reasons for continued stay, and expected disposition.

- Interviews with county staff included questions about the strengths and weaknesses of the various IMDs used by the county and about their monitoring and quality improvement efforts.

OVERALL FINDINGS

Concepts of recovery and rehabilitation are only in the verbal stage – not yet understood or integrated into IMD treatment programs.

In the site visits, the administrator of the IMDs would often articulate recovery principles or even point to recovery principles in policies and procedures, but the tours, discussions with staff and review of charts showed little evidence of implementation of these principles. In some facilities, staff showed no awareness of recovery principles.

In most facilities treatment goals were listed and showed signs of being reviewed on some periodic basis. Even when the goals were concrete and specific they rarely related to discharge issues or capacities for living in the community. There were no instances of

goals stated in the client's terms and while a few programs noted staff responsibilities in relationship to the goals, only a few showed corresponding client responsibilities. Here are some comments of the reviewer about different facilities:

- The program as presented was quite comprehensive and excellent. We were assured that recovery principles were in place ….There was no evidence of recovery principles in any chart.

- They do not see themselves discussing recovery principles with clients because they are "too acute."

- Treatment plans were current, specific, and had goals for the clients, but did not address the clients' goals. They were not oriented to community living or barriers to discharge and did not list specific responsibilities.

- The staff of this facility had no idea what recovery principles might be. They were more oriented to nursing home operations than psychiatric care…. Questions on recovery or even cultural competence brought about blank stares.

- Charting in nearly all facilities is more related to licensing requirements than client needs and differences. With the exception of medication prescribed and doctors notes, charts tell little about the care that the client receives.

The treatment goals recorded for the clients in the Long-Stay Study were largely generic and indicated virtually no client input.

The point-in-time assessment of clients in the Long-Stay Study included the listing of the current treatment goals for the clients. We grouped the goals into general categories with behavior management, treatment compliance, and symptom management encompassing the highest percentages.

Goals (N=180)

Category	*Examples*	*Percent*
Behavior management	Reduce assaults, reduce verbal abuse, recognize aggressive feelings prior to assault, improve impulse control, communicate needs in a constructive manner without yelling, stop harassing behavior	23%
Compliance with treatment	Attend more groups, improve meds compliance, cooperate with current treatment plan, co-operate with ward routine, attend all assigned groups for 90 days, attend Latino group to increase socialization, attend music group 2X month to decrease agitation, attend anger management group at least 1X month	19%
Symptom management	Reduce hallucinations, reduce paranoia, develop symptom management, decrease nonfactual statements, utilize more effective coping tools to deal with psychotic symptoms, seek out staff 3X week to express paranoid ideas, mood instability, depression	18%
Activities of Daily Livings (ADL)	Improved hygiene, perform ADLs daily, compliance with toileting program, shower once a week, noncompliant with ADLs,	7%
Court issues	Attain trial competence, resolve Murphy conservatorship, verbalize understanding of court process,	7%
Social behavior	Reduce isolation, verbalize in a socially appropriate manner, improve communication, interact with staff and peers without being verbally aggressive, social skills	6%
Mood issues	Mood instability, depression, reduce agitation	6%
Discharge planning	Stabilize and discharge to lower level of care, discharge planning, decrease client's anxiety about discharge, be willing to discuss discharge with staff, place at lower level of care	4%
Health issues	Stable blood pressure, weight gain, nutritional status, reduce visual impairment	3%
Skills or strengths	Low self-esteem, skill management, increase attention span, develop relapse prevention plan for SA	3%
Stability	Be medically and psychiatrically stable, maintain client's current stability,	2%
Judgment and safety	Judgment and safety	1%
		100%

What is most striking about virtually all the goals is that they are generic and flow from a traditional medical model orientation. Only 3% of the goals could be classified (even liberally) as relating to skills or strengths building. And not a single goal appeared to be in the client's wording or reflected anything that was specific to a particular client.

The original intent of the required 27-hours of treatment for Specialized Treatment Program (STP) certification may not be consistent with current treatment approaches.

The state originally instituted the 27-hours of programming requirement for IMDs in order to ensure that clients received active treatment. In reality, the hours requirement is generally filled with very generic group activity, which can be tedious for and irrelevant to many clients. The goal often becomes to get clients to attend the groups rather than having the groups be attractive to the clients and getting the clients to develop and implement an individual recovery plan.

The medication practices were highly variable among the facilities, with the biggest deficits in those facilities without full-time psychiatric coverage.

The Study Team psychiatrist ranked the medication practices of the facilities based on the chart reviews from one to five with one being the best. The table below indicates the rating for each facility along with the number of psychiatrists who are on-site at the facility, a rough approximation of total psychiatric time provided on site and the nature of the relationship among the psychiatrist, the county and the facility. The psychiatrists bill Medi-Cal separately in almost all situations in addition to their other financial arrangements with some counties and/or the facilities.

Facility	# of Beds	Medication Practices Rating*	*Number* of Psychiatrists	*Hours* of On-Site Psychiatrist Time per Week	Relationship to County and/or Facility
1	84	3.1	3.5	140	Contract with county
2	65	3.5	2	16	Facility selected, Medi-Cal only
3	46	2	2	80	County Employees
4	170	2.7	2	30	Stipend +Medi-Cal Other employment is with County
5	120	3.9, 3.2**	3	6-9	Stipend from facility& Medi-Cal
6	95	3.6, 3.5**	3	11	Medi-Cal only +$300/Conserv. hearing
7	120	3.4	2	16	Medi-Cal, some counties pay for non Medi-Cal clients
8	74	3.6	3	1-2	Medi-Cal only
9	64	3.9		8	Stipend from facility + Medi-Cal

* Lower ratings indicate better practices
* *Client charts for two different counties were rated within the same facility.

A most striking feature is the wide variation in the number of hours of on-site psychiatrist time. Those with the largest number of hours and the closest relationship to the county have generally higher ratings by the Study Team psychiatrist.

While inappropriate polypharmacy[5] was not too frequent, appropriate assertive medication management was not often evident.

While medication practices were not the most sophisticated, they were better than expected in the majority of the facilities. With some exceptions, and a good deal of variation among psychiatrists, polypharmacy was less than expected. This seems to be the result of assertive efforts on the part of counties, especially County E and County B.

On the other hand, when clients don't improve, doctors are slow to make changes and seek a better drug regimen. This is likely due to the separation of the psychiatrists from the treatment programs and the fact that they carry large numbers of clients, often in

[5] The use of multiple drugs of the same type; usually such combinations cause excessive sedation and more side effects with little therapeutic advantage. Such practice can be justified for some individuals who do not respond to standard regimens.

multiple facilities. Facilities seemed reluctant to push psychiatrists about their prescribing practices. Those psychiatrists who did respond to counties' prohibition of polypharmacy did not necessarily become better psychopharmacologists. They used less different drugs, but did not practice aggressively, changing medications when needed, pushing doses to maximum effectiveness and justifying the use of multiple drugs when indicated for clients who were not showing signs of improvement. Clozaril[6] was available as an option and prescribed in most of the IMDs.

Many clients' charts in the Long-Stay Study lacked information about the client's medication history.

The survey forms on the long-stay clients asked about medication practices. Roughly one-quarter of the clients were reported to have a medication change over the last year, mostly in the area of neuroleptics.

The survey asked whether the clients had had a trial on Clozaril. Overall, one-quarter had. Of most concern was the fact that in almost half (48%) of the cases the person completing the form (either county or facility staff) did not know. The routine practice of "thinning" charts[7] on clients appears to lead to the loss of information which is vital to the planning of care for these clients.

The facilities show a general awareness of cultural issues but little attention to the impact of culture for individual clients.

Virtually all the facilities had Spanish-speaking staff on all shifts and many reported either Vietnamese or Filipino staff on at least day and evening shifts. Many celebrated ethnic holidays and had policies about cultural competence.

There was more variation in the use of formal cultural competence trainings with some reporting annual trainings for all staff and some no formal training. About half indicated that at least some of their staff had received formal cultural competence training in the last six months. There was not evidence in the chart reviews, however, of any specific treatment goals or issues relative to a client's culture.

Family involvement was limited in most facilities.

At least two of the facilities hold weekly group meetings for family members. And some indicated that they invited family members to treatment planning and discharge planning meetings if the clients so requested. The facilities noted, however, that most clients had no current involvement with family members.

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[6] The first and probably the most effective of the new neuroleptics, but a second line drug due to its potentially lethal side effect of agranulocytosis wherein the body stops producing white blood cells. Careful monitoring with frequent blood draws are troublesome for both clients and treating personnel

[7] Facilities periodically remove older sections of the charts and place these in storage in order to keep the size of the charts kept in the facilities more manageable.

Some of the facilities described challenges with some family members who were private conservators. They believed that these private conservators were fearful of community placement and were sometimes too protective of their family member in their concerns for their safety and well-being.

Overall, 14% of the clients were transferred at some point during their IMD/SH stay.

Overall, there were 66 transfers for these 45 clients. The highest proportion of the transfers (60.6%) was back to an acute care facility from the IMD. The predominant reasons for the transfers were aggressive/assaultive/threatening behavior or self injury/suicidal ideation. Here are some examples given by staff on the transfer forms.

- Threatening to kill everyone, threw tables at staff, broke nurses' station plexiglass
- Client became aggressive toward peers/staff. Unable to control on unit. Refusing lab work.
- Became severely paranoid, verbally threatening, punching in the air, karate kicks, required seclusion/restraints - too violent for facility
- Swallowed tacks, unstable behavior, needs further stabilization
- Assaultive, unpredictable behavior, refuses meds, delusional, punched wall
- Self-mutilation, swallowed glass

Additionally, 7.6% of the transfers were to a medical hospital. There was one pregnant client who was sent to the hospital to deliver, one with AIDS, and three for diagnostic purposes when the client showed slurred speech, unsteady gait, and confusion.

DIFFERENCES AMONG COUNTIES

While all the counties do some on-site monitoring of clients when placed in an IMD, the intensity and focus varies.

The frequency and intensity of the on-site monitoring varies by county depending on the degree of staffing, the location of the IMDs, and the general philosophy of the counties.

- The case managers in County A with a relatively low caseload of 30 see clients in IMDs at least monthly and hold standard reviews quarterly. The major County A facility indicates that county staff are on site almost daily.
- With similarly sized case loads in County E (down from 80 clients/case manager) there are monthly meetings with the IMDs at which clients' progress is tracked. The unit holds a weekly review of all its IMD cases.
- In County D, a LTC unit staff person sees clients weekly and attends IMD team treatment meetings.
- The situation is mixed in County C depending on the facility. Clients in the in-county facilities are actively monitored. Monitoring of clients in out-of-county IMDs is less frequent with at best weekly phone calls and monthly on-site visits to IMDs in near-by counties.

- The five LTC liaisons in County B work closely with the IMD treatment team. The IMDs complete a Multnomah Community Activity Scale (MCAS) on each client quarterly. The county selects roughly 20% of the clients with the highest MCAS scores (a high score means higher functioning) for quarterly reviews and possible discharge.
- In County F, county staff used to visit clients in the IMDs every three to six months in the past. Now they are unable to visit regularly due to lack of staff. Sometimes case managers visit their clients who are placed in IMDs that are not too far away. Conservators try to see their clients. Telephone communication is more frequent. They try to get quarterly reports from the facilities, but it generally takes a reminder.

In addition to ongoing monitoring, some counties have initiated quality improvement efforts.

County B has established the most extensive formal quality improvement initiative. Several years ago, the county began looking at facilities on an informal basis and noted several areas where they thought quality was deficient, including psychiatric care, incident reporting, nursing care and discharge planning. They instituted quality of care surveys done by nursing staff which review each of these areas. Last year the review process was expanded to include the nurse surveyors sitting in on five groups in each facility. Survey results are reviewed with the facility liaisons and the providers. Training is provided to ameliorate any deficiencies. If quality does not improve, a plan of correction is developed with the provider.

County E is another county that has taken a more aggressive posture recently with its IMDs. Staff felt that two of the three major facilities they use have done very well, in part as a result of an increased county mental health staff presence and clarification of expectations. Prior to the concerted effort to work with IMDs, the MH Department did not have much of a relationship with these facilities. Now they are working together on values clarification and working on medication monitoring guidelines. All of the facilities come to monthly meetings in which they talk about care for clients.

Three of the counties – County F, County C, and County E - had substantially higher rates of client transfers then the others.

The table below shows the number of clients who were transferred by county. In addition, five of County F's 10 clients in the Tracking Study were transferred during the Study.

Number of Transfers	County A (N=30)	County B (N=135)	County C (N=60)	County D (N=29)	County E (N=60)	Total (N=314
1 Transfer	2	4	15	2	7	30
>1 Transfer	1	1	3	1	9	15
Total Number Transferred	3	5	18	3	16	45
Total Percent Transferred	10%	3.7%	30%	10.3%	26.7%	14.3%

The reasons why the three counties have higher than average transfers are in some cases fairly clear while in others less clear.

- County E**:** This county had the most total transfers (30) which represents 47% of all the transfers for the total Study sample. All but one of these were transfers back to an acute psychiatric hospital unit. It is unclear from the data whether this results from differences in the patient population[iv] or IMDs which are simply less able and/or willing to continue to serve clients who exhibit challenging behaviors.

- County C**:** By contrast, County C which had 21 transfers (32% of all the transfers) had a variety of movements among IMDs, reflective of the way in which they have organized their system. Clients go first to the short-term in-county facility and if not discharged from there, usually with a short length of stay[8], will be transferred to other longer-term out-of-county IMDs (4) or to another IMD/MHRC which is considered a lower level-of-care in their system (8). Only five of the transfers were back to acute.

- County F: County F county staff noted during the site visit that the IMDs seemed to be requiring readmissions to the county Psychiatric Health Facility (PHF) for conditions which they believed the IMDs should be able to manage. Two clients were transferred twice to the PHF. The length of stay at the PHF before return to an IMD ranged from one client staying just overnight but most staying 2-3 weeks. Most of the returns were to the same IMD, but there was an occasional return to a different IMD. The fact that the IMDs are out-of-county limits the ability of the County F staff to assess the immediate need for a transfer.

Discharge and Transition to Community Placement

OVERALL FINDINGS

About half of the clients in the Tracking Study had a planned discharge to the community during the study period with an average length of stay of about 6 months.

[8] The average length of stay for clients discharged from the short term facility was 3.7months with a median of 2.8 months.

Overall, 54% of the clients had a planned discharge during the course of the Tracking Study. The mean length of stay was 5.8 months and the median 5.3 months. Another 10% of the clients had an unplanned discharge and 36% were still in the IMD/SH at the end of the Study period.[v]

Clients with a planned discharge showed significant gains in functional status since admission to the IMD/SH.

The table below shows the differences in the MCAS scores of the 126 clients on whom we have an MCAS score at the time of intake and at the time of the planned discharge.

MCAS Scores at Intake and at Time of Planned Discharge (N=126)

	Initial MCAS	MCAS at Discharge
Mean	51	61
Median	50	62
High	14%	48%
Medium	48%	43%
Low	37%	9%
	100%	100%

About one-third of the clients with a planned discharge were not expected to do well or to do "just OK" in the community.

Staff were asked to rate how well they thought the client would do when discharged into the community: 16% said "not very well" and another 20% said "just OK." The GAF and MCAS scores for those rated as expected to not do very well are significantly lower than for the rest of the discharged clients. (See Table in Appendix C).

For those they rated as doing not very well or just OK, they were asked to indicate what they thought the obstacles were to not doing better. The table below shows those reasons sorted into 9 categories for the 39 clients so rated. Unwillingness to participate with prescribed treatments is the most frequently cited reason followed by the presence of psychotic symptoms or problematic Axis II behaviors. (See Appendix C for some staff comments about these clients.)

Obstacles for Those Expected to Do "Not very well" or "Just OK" (N=39)

Obstacles to Doing Well in the Community	Number	%
Noncompliant with medications/refuses follow-up treatment	17	*44%*
Presence of psychotic symptoms or Axis II behaviors	14	*36%*
Substance abuse	7	*18%*
No or minimal social support	6	*15%*
Issues with family or private conservator	6	*15%*
Likely to decompensate without structured environment	3	*8%*
Behaviors more than board/cares able to cope with	3	*8%*
No appropriate treatment available	2	*5%*
Unable to care for self	1	*3%*

Percentages add to greater than 100% because more than one item was cited for some clients.

Ten percent of the clients had an unplanned discharge during the course of the Study.

The most frequent reason for an unplanned discharge is the client's going Absent Without Leave (AWOL); this represents 32% of the unplanned discharges. The second most frequent reason is the client's leaving the facility after the conservatorship is dropped or as a result of a writ hearing.

Reasons for Unplanned Discharges

Reasons for Unplanned Discharge	Number	%
AWOL	10	*32%*
Involuntary status (usually conservatorship) removed and client left	9	*29%*
Taken to jail after assault or discovered that a warrant out	5	*16%*
Family-related, e.g. parent is conservator and took client out Against Medical Advice (AMA)	3	*10%*
Transferred to medical or psychiatric acute and whereabouts unknown thereafter	3	*10%*
Other	1	*3%*
TOTAL	31	*100%*

DIFFERENCES BY COUNTY

County B and County F had significantly lower percentages of clients with a planned discharge than the other counties.

While the overall rate of planned discharge during the Study was 48%, this was skewed by County B with planned discharges for only 38% while the other four counties were close to two-thirds. County F discharged only two of the ten clients in the Tracking Study.

Percentage Discharged By County

	County A (N=30)	County B (N=136)	County C (N=60)	County D (N=29)	County E (N=60)	*Total (N=315)*
Planned Discharge	70%	38%	65%	66%	63%	*54%*
Unplanned Discharge	3%	14%	10%	10%	7%	*10%*
Not Discharged	27%	48%	25%	24%	30%	*36%*

County B was also an outlier in terms of ALOS before planned discharge with an average of 8 months compared to 4-5 months for the other counties.

At least 80% of the clients in County A and County C counties and 71% of the clients in County E were discharged within six months while in County B this figure was only 22%.

Lengths of Stay for Clients With a Planned Discharged (N=169)

	County A (N=21)	County B (N=52)	County C (N=39)	County D (N=19)	County E (N=38)	*Total (N=169)*
Mean	4.8	8.3	4.2	5.1	4.8	*5.8*
Median	4.8	8.2	3.0	4.6	4.2	*5.3*
< 3 months	24%	8%	49%	21%	21%	*24%*
3-6 months	57%	13.5%	33%	37%	50%	*34%*
6-9 months	14%	34.5%	13%	26%	24%	*24%*
>9 months	5%	44%	5%	16%	5	*18%*
	100%	100%	100%	100%	100%	*100%*

Functional status scores on the MCAS were roughly comparable at time of planned discharge except for County D which had lower scores.

The lower MCAS scores at discharge in County D reflects their overall orientation to the use of locked care only as a temporary measure with discharge as soon as possible.

MCAS at Time of Planned Discharge by County

	County A (N=18)	County B (N=36)	County C (N=37)	County D (N=17)	County E (N=30)	*Total (N=138)*
Mean	64.5	64.3	59.0	48.6	62.1	*60.7*
Median	65	65	60	47	63	*62*
High	72%	69%	35%	6%	53%	*48%*
Medium	28%	31%	57%	47%	43%	*42%*
Low	0	0	8%	47%	3%	*10%*
	100%	100%	100%	100%	100%	*100%*

The discharge living situation and the presence of intensive case management reflect the varying strategies of the counties towards "step-down" services.

Interviewees generally expressed the belief that for most clients the move from the highly structured IMD situation to an unstructured community living situation is too great a shift, creating a higher potential for difficulties than is desirable. Counties try to address this discontinuity in the intensity of services by one of two approaches: non-locked residential settings with staffing greater than is present in a regular B/C or Assertive Community Treatment (ACT)-like intensive case management programs with caseloads of less than 15.

There were significant differences among the counties in the living situations to which clients were discharged. Roughly two-thirds of the clients in County B and in County D were discharged to a B/C facility. County E, on the other hand, discharged roughly three-quarters of its clients to a residential program. County A split its discharges between a residential program and B/C facilities. County C stands out with the largest percentage (42%) of its discharges to living arrangements with family members.

Living Situation for Clients with a Planned Discharge by County

	County A (N=20)	County B (N=36)	County C (N=38)	County D (N=19)	County E (N=37)	*Total (N=150)*
Residential Program[9]	40%	14%	16 %	5%	70%	*31%*
Board and Care	45%	64%	24%	68%	11%	*39%*
SRO or Room/Board	0	0	16%	0	0	*4%*
Family	10%	19%	42%	11%	5%	*19%*
Independent or Supported Housing	5%	0	3%	16%	3%	*4%*
SNF or Medical Hospital	0	3%	0	0	11%	*4%*
	100%	100%	100%	100%	100%	*100%*

The alternative strategy of using intensive case management programs is most apparent in County D, which instituted an ACT-type program specifically to further reduce its IMD usage. County A and County B also use intensive case management. All County B discharges are now supposed to be placed with an ACT-type program. Neither County C nor County E used intensive case management as a step-down resource for clients discharged from IMDs.

[9] Residential facility was defined as a site with licensed staff.

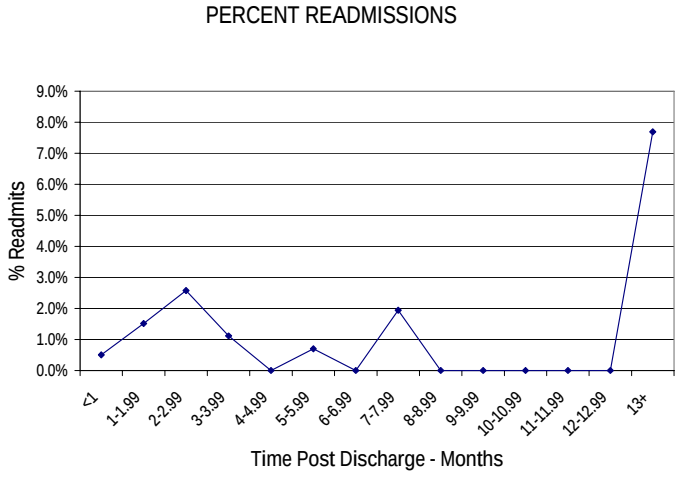
Percentage with Case Managers By County

	County A (N=20)	County B (N=35)	County C (N=39)	County D (N=19)	County E (N=35)	*Total (N=148)*
Have a case manager	100%	80%	69%	63%	94%	*81%*
% of discharged with case manager with caseload 15 or less	35%	26%	0	58%	0	*18%*

Thus, County D and County B have one approach to step-down which is the use of intensive case management while County E is relying more on residential programs. (See the Case Study of County E in Appendix B for a description of the residential programs they have initiated.) County A appears to rely on both strategies with the use of residential programs and intensive case management. County C appears to not use either, and seems at the same time to have an unusually high percentage (40%) of discharges to the family.

In the Tracking Study, 7½% of the discharged clients were readmitted to an IMD during the remainder of the Study.

There were 15 clients who were re-admitted, 14 once and one twice. This is 7.5% of the 201 discharged clients. The average time to re-admission was 4 months, with a median of 2.8 months, but this data reflects only a partial story because the relatively short time frame for the whole Study limited the number of clients who were in the community for long periods after discharge. The figure below shows the percent of clients who were readmitted in each month using as the denominator the number of clients who had been in the community that number of months post discharge.



Clients with very low functional status scores and/or clients who staff are concerned about seem to have a higher likelihood of being readmitted.

There are no clear predictors of readmissions, but some interesting possibilities. There is some support for the hypothesis that those with lower functional scores at the time of discharge are more likely to be readmitted, but this appears to hold largely for those with the very lowest scores. The staff's prediction at discharge about how well the client would do did seem to be related to whether or not the client was readmitted, but the relationship was not statistically significant.

Readmissions by Staff Predictions

How Well Will Client Do	*N*	*% Readmitted*
Very well	25	4.0%
Moderately well	58	6.9%
Just OK	26	11.5%
Not very well	21	19%

A number of other characteristics of clients at discharge were not related to whether or not the clients were readmitted. These included their living situation, their civil commitment status, whether they had a representative payee, whether they had a case manager, or whether the discharge was planned or unplanned.

There are some differences among the counties in the readmission rates, but the small numbers and the lack of a long enough follow-up period makes interpretation of the differences too problematic. It would be useful to be able to continue follow-up on this cohort of clients since it represents a rich data source.

Clients who are discharged and not readmitted appear to at least maintain their status while in the community.

Most counties attempted to complete a community follow-up form on clients approximately 3 months after their discharge and again near the end of the study period. Not all counties were able to do this and not all clients could be located or, if located, not all clients were willing to provide information. For most of the items that follow there were 90 clients at the three-month follow-up and 60 at the final follow-up.

- *Living Situation*. The most common living situations at follow-up are residential programs, B/C, and family of origin. There is a promising trend towards an increase in independent and supported independent living over the intervening time period.

- *Income*: Roughly three-fourths of the clients were reliant on SSI as their primary source of income at both three-months and final follow-up.

Significantly, by the final follow-up no clients were noted as having "no income", but only one was listed as having income from employment.

- *Conservatorship.* Somewhat more than half of the clients remain on conservatorship at the three-month and final follow-ups. There is also virtually no change over the intervening time period.

- *Criminal Justice Involvement:* At both the three-month and the final follow-up roughly 10-11% of the clients were reported to have some involvement with the criminal justice system. Of the total clients at follow-up 14.4% had reported involvement with criminal justice at either the three-month and/or the final follow-up.

- *Functional Status:* There was basically no change in GAF scores between discharge and follow-up. The median GAF score was 40 at discharge, three-month follow-up, and final follow-up. The average GAF at discharge for those with any follow-up GAF was 43.6 compared with an average three-month follow-up GAF of 42.4 and an average final follow-up GAF of 41.6.[10]

FACTORS INFLUENCING CONTINUED STAY IN AN IMD/SH

OVERALL FINDINGS

Functional status is clearly a factor for clients who remain in an IMD/SH.

Functional status scores are lower for clients in the Long-Stay Study and for the clients in the Tracking Study still in the IMD/SH at the end of the Study than for those discharged. The scores of the clients still in the IMD/SH are comparable to those for the Tracking Study clients at Intake into the IMD/SH (mean and median of 50).

[10] MCAS scores were collected on follow-up in selected counties, but we do not include the information since it is not comprehensive and because the knowledge of clients specific functioning was likely not very reliable at follow-up since staff were not in regular face-to-face contact with the clients.

MCAS Scores at Planned Discharge or Final Status for Tracking Study and for Long-Stay Clients

	Tracking Study: Planned Discharge	Tracking Study: Still in IMD/SH	Long-Stay Study
Number of clients	138	98	192
Mean	60.7	53.4	49.7
Median	62	53	49
High	48%	18%	8%
Medium	42%	49%	46%
Low	10%	33%	45%

Further, there is a relationship between expected disposition and MCAS scores for clients in the Tracking Study.

Staff were asked to indicate the expected time until discharge for clients still in the IMD/SH at the end of the Tracking Study. Most (71%) of the clients with a high MCAS score were expected to be discharged within the next three months, whereas over half (56%) of those with a low MCAS score were expected to stay at least another 9 months..

Expected Time Until Discharge by MCAS Score Categories

Expected time until discharge	High MCAS	Medium MCAS	Low MCAS
Less than 3 months	71%	24.5%	3%
3-6 months	12%	14.5%	13%
6-9 months	18%	39%	28%
9-12months	0	10%	28%
Over 1 year	0	12%	28%
	100%	100%	100%

Over half the Long-Stay clients had at least one of four serious conditions (homicidal, suicidal, violence toward self or others). The following table indicates the percentage of the long-stay clients who were noted as having each of the four conditions, followed in parentheses by the percentage who had exhibited the behavior within the last three months. Violence towards others was by far the most frequent of these conditions.

Current Condition for Clients in Long-Stay Study

Condition	*% (N=193)*
Suicidal	12% (4%)
Homicidal	9% (5%)
Violence-Self	14% (8%)
Violence-Others	48% (30%)
Any of four	*56% (35%)*

The percentage of organically impaired clients is about twice what it was for the Tracking Study clients.

Other Conditions of Clients in Long-Stay Study

Condition	%
Substance abuse (last 3 months)	25% (5%)
AWOL risk (last 3 months)	12% (2%)
Medication noncompliance	52%
Communicable disease and unpredictable behavior	6%
History of fire setting (last two years)	4% (0.5%)
Organically impaired	11%
Known history of abuse or trauma	12%

The reasons cited for why clients are still in the IMD/SH are generally similar for both those clients in the Tracking Study and in the Long-Stay Study.

Staff were asked to describe why the clients were still at this level of care. The answers for the long-stay group of clients were grouped into 17 different categories. The same categories were then used for the clients still in the IMD/SH at the end of the Tracking Study with the addition of four other categories. The top category for both groups was the continuation of psychotic symptoms. The next reasons for both groups were dangerous to others, impaired decision making and symptoms of mood disorders.

Differences between the groups existed with a couple of categories. Discharge issues, sexual issues, and being verbally abusive were more prominent with the long-stay clients while refusing or not participating in treatment and history of prior problems were more common with the Tracking Study group

Reasons Given for Why Clients Remain in IMD/SH for Long-Stay and Tracking Study Clients

Reason	*Long-Stay*	*Tracking Study*
Responses to internal stimuli, hallucinations, delusions, bizarre behavior	34%	39%
Dangerous to others, assault, throws things, threatens	29%	23%
Impaired decision making, no insight, poor judgment, safety issues without supervision	22%	26%
Mood disorder: depressed, agitated, labile	21%	24%
Discharge issues: client doesn't want to leave, family/conservator doesn't want discharge, no place will take client, no benefits, client decompensate when DC is planned	21%	5%
Needs assistance with ADLs, needs reminders to shower, poor hygiene,	14%	12%
Refuses treatment, no or spotty attendance at groups, tries to avoid medications	14%	22%
Sexual issues: inappropriate sexual behavior, inappropriate touching	12%	3%
Poor social adjustment: isolated, withdrawn, intrusive	11%	12%

Disorganized, disoriented, confused, need for supervision	10%	8%
Verbally abusive (without danger to others)	8%	0
Dangerous to self, self-injury, suicidal thoughts and expressions	7%	9%
Danger to community if discharged	5%	3%
Major ADL issues: incontinence, smearing feces, total inability to care for self	5%	0
Medical issues: dementia, seizures, end stage of illness, lymphoma, end stage renal failure	4%	2%
Current stealing	2%	1%
Criminal issues still not resolved	2%	0
Benefiting from treatment	0	3%
"Attempts to maintain whatever gains have been made from intensive treatment have limited success"	0	5%
Ready or almost ready for discharge	0	8%
History of assaults, AWOL, substance abuse, meds noncompliance	0	6%

Numbers do not total to 100% because more than one reason was cited for many clients.

Certain characteristics of long-stay clients are related to the reasons why staff say they are still in the IMD/SH.

The reasons for still being in the IMD/SH were further grouped into four major categories, as follows.

- Dangerousness which includes dangerous to others, sexual issues, danger to community, and criminal issues still not resolved
- Safety which includes dangerous to self, disorganized, impaired decision-making, the serious ADL issues, and current stealing
- Grave disability which includes responds to internal stimuli and needs assistance with ADLs
- None of the above categories.

Frequencies of these larger categories are as follows, with the percentage in parentheses indicating the percentage of clients for whom it was the only reason cited. The majority of clients had more than one general reason, and 20% had no reason that fit into any of the three major areas.

Major Categories of Reasons for Still in IMD/SH for Long-Stay Clients

Dangerous	45% (20%)
Safety	39% (12%)
Grave Disability	42% (15%)
None	20%

The following are the significant relationships.

- Dangerousness is clearly cited more frequently for males and those in a SH as opposed to an IMD. It is also related to age with its being more frequent with those under thirty and less frequent with those over 50.

- Safety is cited more frequently for females, for those over age 40, and for those in IMDs as opposed to the SH. It is inversely related to total MCAS scores with its being cited more often for those with lower MCAS scores. It is also directly related to the time a person has spent in an IMD/SH with its being cited for 8% of those with a LOS of fewer than 3 years and by 55% for those with a LOS over 8 years.

- Grave disability is cited more frequently for those in a SH vs. an IMD and not surprisingly is inversely related to MCAS scores with those scores over 56 having the lowest likelihood of having a grave disability reason for still being in the IMD/SH.

- Grave disability only (i.e. with no dangerousness or safety issues) is somewhat more frequent with females, and more frequent with older clients, particularly anyone over 65.

- Not having any of the three reasons cited is more frequent for those missing a diagnosis, those with an MCAS score over 56, and for those who have been there for shorter periods of time.

There are 20% of the clients in the Long-Stay Study who had none of the three major reasons for still being in an IMD/SH.

The most frequent reason (11% of total sample) cited for these clients was a discharge-related reason, e.g. client or conservator either refuses discharge or decompensate when discharge is discussed or there is no appropriate placement for the client in the discharge process.

About one-third of the clients in the Long-Stay Study are expected to remain in the IMD/SH for the foreseeable future.

There is a significant relationship between expected length to remain in the IMD/SH and MCAS scores. Seventy percent of those with high MCAS scores have an expected further stay of less than one year with only 14% expected not to be discharged at all. Only 28% of those with the lowest MCAS scores are expected to leave within a year with 45% expected not to be discharged at all.

Expected Length of Time in IMD/SH by MCAS Scores

	Low (N=86)	Medium (N=88)	High (N=14)	Total (N=188)
Less than 6 months	7%	15%	50%	14%
6 months to one year	21%	31%	20%	26%
One to two years	27%	29%	7%	27%
Likely to remain at this level of care forever	45%	25%	14%	33%
	100%	100%	100%	100%

There is also a significant relationship ($p<.001$) between the expected time to discharge with a "safety" reason for still being in the IMD/SH.

"Safety" Reason for Still Being in IMD/SH by Expected Time Until Discharge (N=189)

	Safety Reason	No Safety Reason
Less than 6 months	3%	21%
6 months to one year	21%	29%
One to two years	29%	25%
Likely to remain at this level of care forever	47%	25%
	100%	100%

One might expect that every alternative medication would have been tried with those clients with the worst prognosis- i.e. those not ever expected to be discharged to a lower level of care. In fact, these clients were more likely to have been tried on Clozaril (36%) than those with an expected discharge, but this is still only about one-third of these clients.

When a client has been in an IMD for over five years, staff expectation for a discharge is less than 50%

As shown in the table below, once someone has been in an IMD for more than five years the staff perspective of the chance of being discharged appears to be less than 50-50 (48% for those there from 5-8 years and 35% for those there more than 8 years). This relationship does not hold for clients in a SH, largely because as noted below we have considered a transfer to an IMD as a discharge.

Percent Expected to Be Discharged at Some Time By Length of Stay in IMD or SH

LOS in IMD or SH	IMD (N=114)	SH (N=70)	Total (N=184)
< 3 years	72%	100%	76%
3-5 years	67%	67%	67%
5-8 years	48%	64%	54%
Over 8 years	35%	74%	59%
Total	61.5%	73.6%	65%

Virtually all the SH discharges are to an IMD or Skilled Nursing Facility (SNF) level of care.

Staff were asked what the expected placement would be for those clients who they anticipated might be discharged at some point in the future. Seventy-five percent of the anticipated SH discharges were to an IMD and another 15% to a SNF. We do not know what percentage of these clients might be discharged to the community after the transfer to an IMD. So, if one is talking about a discharge to the community, the one-third figure of clients cited above could be higher.

Anticipated Discharge Placement by IMD/SH

	SH (N=53)	IMD (N=72)	Total (N=125)
IMD/Locked SNF	75%	18%	42%
Residential treatment	2%	18%	11%
Augmented board & care	2%	32%	19%
Regular board & care	0	23.5%	
Regular SNF	15%	5.5%	10%
Other	6%	3%	4%
	100%	100%	100%

For the IMDs, the most frequent anticipated discharge placement is augmented B/C (32%) followed by regular B/C (23.5%), residential treatment (18%), and other IMDs (18%).

DIFFERENCES AMONG COUNTIES

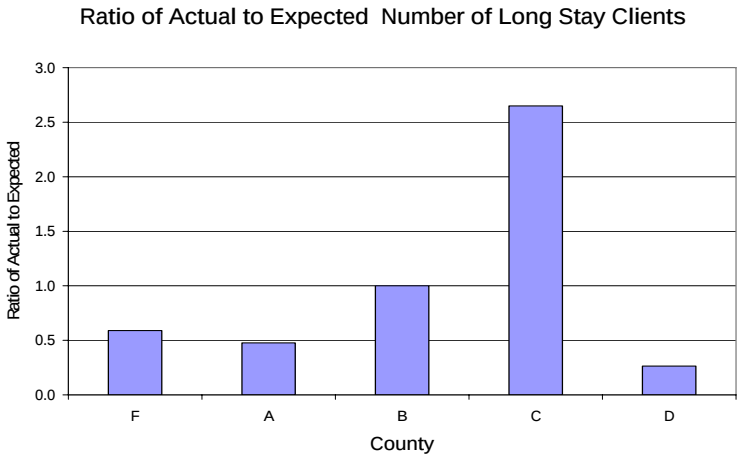
Counties C and E have relatively more clients who have been in IMD/SHs for over 18 months.

The table below shows the number of clients that each county had an IMD or SH with a length of stay over 18 months as of the Fall of 2004 divided by the number of adults in the county and then the number of adults under 200% of poverty. County A and County D had rates of long-stay clients that are at least four times lower.

Rates of Long-Stay Clients by Population and Poverty Population

	County F	County A	County B	County C	COUNTY D	County E
# of clients/adult pop	5.6	2.5	4.6	11.8	1.4	8.4
# of clients/adults < 200% poverty	14.3	6.5	13.1	49.1	4.2	53.3

The figure below shows the number of actual Long-Stay clients compared to an "expected" number based on the same "relative needs/resources" index used in the examination of admits into the Tracking Study. County B is used as the base county, therefore by definition having a ratio of one. Compared to County B, therefore, both County C and County E have over two times their expected number of long-stay clients while County F, County A, and County D have fewer than expected. It needs to be remembered that this does not imply anything about the correct number of long-stay clients – it merely reflects the relative number of long-stay clients in relationship to the county's mental health needs/resources compared to each other.



Over 40% of the long-stay clients in Counties F, C and E are not expected to ever go to a lower level of care.

There are major differences in the expectations about remaining lengths of stay by county. Clearly, County D expects to discharge these clients – about three-quarters within a year. For County C and County E, no discharge is expected for at least 40% of the clients. For County F, five of the seven clients in the Long-Stay Study were expected to remain at this level of care forever. While the numbers are obviously small, this is a considerably dimmer expected disposition than found with any of the other counties.[11]

[11] County F also showed signs of increased expected lengths of stay in the Tracking Study. By the end of the Study 5 of six clients who had been in the IMD for six months already were expected to stay at least one more year.

Long-Stay Study Expectations about LOS

	County B (N=90)	County C (N=45)	County D (N=13)	County E (N=41)	Total (N=189)
Less than 6 months	17%	9%	38.5%	5%	14%
6 months to one year	32%	24.5%	38.5%	19%	26%
One to two years	22%	24.5%	15%	42%	26%
Likely to remain at this level of care forever	29%	42%	8%	44%	34%
	100%	100%	100%	100%	100%

PREDICTORS OF DISPOSITION IN TRACKING STUDY

The issue discussed in this section is whether one can predict the disposition of clients based on their characteristics at intake.

The relationships between client characteristics and disposition (planned discharge vs. continued stay) described above are all based on characteristics at the time of disposition. For example the MCAS scores of the clients when they were discharged were higher than for those clients who were still in the IMD/SH at the end of the Study.

The question here is whether there are any characteristics of the clients at the time of intake that predict whether or not they will be discharged during the course of the Study.

Two factors - age and civil commitment status – show relationships with disposition, but are difficult to interpret.

The older the client is the less likely s/he will be discharged during the Study period. This could be a function directly of age; or of the older clients having a longer history and therefore more issues related to community placement (e.g. being known for destructive behaviors); or a lack of an older adult system of care; or other factors.

Disposition By Age (p<.04)

Age at Intake	N	Planned Discharge	Still in IMD/SH
<21	16	87.5%	12.5%
21-30	18	69%	31%
31-40	65	64.5%	35.5%
41-50	73	59%	41%
51-65	61	49%	51%
65+	6	33%	67%

Another factor which was different was the civil commitment status with those on temporary conservatorships more likely to be discharged. This could again be a function of those with more chronic situations already being on conservatorships or could be influenced by some temporary conservatorships being dropped with clients then leaving the IMD/SH against medical advice (AMA), of which there were some. In other words, it is difficult to know which causes which. This could also be related to the wide variability among counties in the use of temporary and permanent conservatorship.

Disposition by Civil Commitment Status (p<.001)

Civil Commitment Status at Intake	N	Planned Discharge	Still in IMD/SH
180-day	15	80%	20%
Conservatorship	1622	49%	51%
T-Con	90	79%	21%

Functional status scores are not predictive except perhaps for those with high scores.

There were no differences between the GAF score at intake and no more than a tendency with MCAS scores for those with the highest scores to be more likely to be discharged than those with medium and low scores.

Disposition by MCAS Categories (p<.11)

MCAS at Intake	N	Planned Discharge	Still in IMD/SH
High	27	78%	22%
Medium	119	58%	42%
Low	96	55%	45%

Variables that are NOT related to disposition are gender, ethnicity, living situation at time of initial placement, diagnosis, non-compliance with medications, and AWOL risk.

And surprisingly there are a few factors which appear to be predictive in what we might consider an opposite direction. Those with a recent history of being a danger to self or others or at risk of harm are *more* likely (p<03) to be discharged (66%) than those without such a condition (52%).

Functional status and current behavioral conditions at three months are predictive of subsequent disposition.

The situation changes when one looks at the predictors once clients have been in the IMD for at least 3 months. The tables below are the results of the forms filled out at approximately 3 months after the client entered the IMD/SH. It does not, therefore, include those that have already been discharged in those first three months. At this point functional status and current behavioral conditions are more predictive of whether or not the client will be discharged during the remainder of the Study period.

First are the set of conditions that the staff rated – whether the client had been homicidal, suicidal, a danger to self or others, or done things likely to harm self or others. The following were the relationships which were predictive of disposition.

Disposition by Condition in IMD/SH at Three Months (all p<.001)

Condition at Three Months in IMD/SH	N	Planned Discharge	Still in IMD/SH
Violence to Others			
Yes	32	25%	75%
No	250	64%	36%
Homicidal, suicidal, or violence to self or others			
Yes	45	31%	69%
No	237	65%	35%
Homicidal, suicidal, violence to self or others, or likely to harm self or others			
Yes	66	35%	65%
No	216	68%	32%

The differences between functional status at three months and eventual discharge is also clear and statistically significant.

Disposition by GAF at Three Months (p<.001)

GAF at Three Months	N	Planned Discharge	Still in IMD/SH
<20	16	19%	81%
21-25	35	26%	74%
26-30	57	44%	56%
31-35	42	57%	43%
>35	34	71%	29%

Disposition by MCAS at Three Months (p<.03)

MCAS at Three Months	N	Planned Discharge	Still in IMD/SH
High	19	79%	21%
Medium	74	57%	43%
Low	37	32%	68%
TOTAL	130	53%	47%

These findings imply that by the end of three months it is more predictable who will be able to be discharged by the end of a year's time and who will not.

FINDINGS AND RECOMMENDATIONS

This section of the report contains the major findings of the study. These are followed by recommendations and suggested actions for consideration by counties and the state in the continuing effort to better understand and achieve appropriate utilization of IMDs and State Hospitals.

FINDING 1: INDIVIDUALS WHO ARE PLACED IN IMD/SHS HAVE SIGNIFICANT CURRENT DISABLING ISSUES.

Overall, almost half of the clients in the Tracking Study had at least one of four serious conditions (homicidal, violent toward others, violent towards self, expressed suicidal intent) within thirty days prior to their admission. In addition, 29% were homeless prior to admission, substance abuse was a factor in triggering the episode leading to IMD placement for one-quarter of the individuals, and 23% had moderate or marked health impairment. Fifty-six percent of the clients in the Long-Stay Study had at least one of the four serious conditions and 35% had exhibited at least one of those four within the last three months. The Study confirms that counties use IMD placement for their clients who have the most serious issues and challenges. It is precisely because these clients are so vulnerable, and their illness is so serious that they deserve the system's best efforts to aid them in their recovery.

FINDING 2: COUNTIES THAT ADOPT COMPREHENSIVE COORDINATED EFFORTS ARE ABLE TO POSITIVELY AFFECT THEIR UTILIZATION OF IMD/SH RESOURCES.

Many county mental health departments feel pressure to reduce their level of IMD/SH usage for a variety of financial, regulatory, and clinical reasons. Whatever a county decides is an appropriate level of usage is for its particular circumstances, there are actions it can take to reach this optimal level.

2A*: There is no "gold standard" for IMD/SH use.*

This study did not result in a determination of the "correct" level of utilization of IMDs. IMDs serve an important role in providing structured placements when clients are no longer in need of hospitalization and are unable to live in the community due to resource issues or due to the clients' functional ability, medical conditions or safety. Some counties use these facilities for both short-term "stabilization" after an acute care stay and for clients whom they feel need a longer-term very structured treatment setting.

IMD/SH utilization rates consist of at least three components: rates of admission to IMD/SH, discharge rates, and lengths of stay. A county that wishes to examine its use rates must consider all three of these elements in order to understand how IMD/SH are being used. Without an appropriate standard of IMD utilization, comparisons among

counties can be helpful in analyzing effective practices. Timely and accurate statewide data is necessary to do this. At this time, the statewide data that is available is not adequate.

2B*: Initiative and leadership make change in use possible.*

The initiative for change can come from multiple sources and occur for multiple reasons, but for there to be a change there needs to be a "champion" and there needs to be either initial or ultimate buy-in by the leadership of the mental health department.

The two counties with the lowest use rates trace system change back to a particular strongly-felt and pursued concern about the way in which the IMD/SH level of care was being used. In both, the impetus was a concern about clients' rights and the inappropriate use of restrictive settings. In one county the initiator was the Patient Rights unit and in the other the Mental Health Department. In both of these counties the concerns have been fully embraced by the leadership of the mental health departments.

In two other counties change is also underway. In one the initiation came from concerns (initially surfaced in newspaper articles) about the quality of care in IMDs. In the other, new department leadership undertook change in the LTC system as a result of major budgetary shortfalls and a chronic service back-up in their Psychiatric Emergency Services (PES). Again, in both these counties, leaders within the Department of Mental Health have the issue of LTC high on their lists of priorities.

2C*: A clinical/treatment vision that sees IMD/SH placement within a system that is dedicated to client-directed services and recovery facilitates change.*

While the initial concern about IMD/SH usage may result from a clients' rights or budget constraints perspective, the existence of a consistent clinical/treatment philosophy which promotes a client-directed recovery system of care provides an invaluable support to the implementation of change. Under such an overall philosophy IMD/SHs become a placement of last resort and both community and IMD staff communicate to the client that the placement is temporary. While IMD/SH usage can be controlled by strictly administrative means – e.g. by simply insisting on not exceeding a set number of budgeted bed days –more effective control is achieved when the control is both clinical and administrative. Clinicians become allies when the treatment philosophy is congruent with the administrative goals.

2D*: Effective supporting structures and processes are necessary to make changes.*

Although all six counties in the Study had centralized[12] intake and monitoring functions, their effectiveness varied greatly. Factors that seem to influence effectiveness of a centralized process include having

[12] By centralized we do not necessarily mean just one unit for a large county. What is intended is a centralized unit for some geographical area – which could be a region in a large county.

- Adequate staff to both (a) conduct a timely and thorough evaluation when a referral is made to ensure that there are no other alternatives that could avoid an IMD admission and (b) follow-through with regular and frequent on-site monitoring of clients while they are in IMD/SHs.
- Skilled clinicians who also have knowledge of the resources available in the community that might serve as alternatives and discharge placements.
- Budgetary control over the IMD/SH resources.
- Presence of strong and visible support for the function from the top administrators in the mental health program. The role of gatekeeper and monitor can be difficult without the support and encouragement of supervisors and managers.

Counties with IMDs located out-of-county have a more challenging job since on-site monitoring of clients becomes a more costly proposition, but in the long run is likely to be cost-effective as well as more effective clinically.

2E: ***Variations in county implementation of civil commitment procedures can greatly influence IMD/SHs usage.***

Conservatorship policies and practices vary greatly from county to county. Where the conservatorship function is placed in county government, the nature of the relationship between the Public Guardian and the mental health program staff, and the philosophy of the courts and /or Public Guardian affect IMD utilization. PG policies and procedures affect acute hospital lengths of stay, movement out of IMDs, and clients' success in the community. Among the more substantial differences we noted in just the six counties we examined were:

- Use of the 180-day dangerousness certification
- Whether a client can be in an IMD while on a temporary conservatorship
- Whether clients discharged from IMDs should remain on conservatorship while in the community
- How big a role conservators play in the monitoring of client's care in IMDs and doing discharge planning.
- How much influence public and/or private conservators exert in inhibiting discharge because of concerns for client's safety.

Developing a consistent vision and supporting policies and procedures for the appropriate use of IMD/SHs cannot be attained in a county without working closely with all those who implement the county's civil commitment policies and practices.

2F: ***Co-operation among all stakeholders promotes effective management of usage.***

Other stakeholders, besides those directly involved in civil commitment issues discussed above, are affected in major ways by the department of mental health's usage of IMD/SH resources. Among them are clients and client representatives, families, and acute care facilities. For example, families may be concerned that availability of IMD/SH beds is

too restricted to adequately meet the needs of their family members. Also, acute care hospitals may apply considerable pressure to increase access to IMD beds so that they can reduce their administrative days.

Counties that are effective in managing their IMD/SH resources have developed procedures for including these relevant interests in the development of a common vision of what will be considered the appropriate use of these resources. Since interests differ and there is no gold standard, the working through of a common vision is not easy. Counties who have successfully accomplished this have struggled through many contentious meetings about both general policies and specific cases. And the process is continuous as new pressures develop on components of the overall system.

Recommendations

2.1 ***Accurate, timely and comprehensive statewide data on IMD utilization produced by DMH would enable counties to analyze and compare their overall IMD/SH use rates with other counties.*** In the absence of a clear gold standard, comparisons with other counties can be useful in trying to understand in which areas, if any, a county diverges from common practice. This involves looking at admission rates, lengths of stay, and proportions of long-stay clients. In order to do this, counties need access to timely and accurate data from the State DMH on at least an annual basis. Analysis of this data can provide useful information that will allow counties to focus attention on areas in which they may want to make changes.

2.2 ***It would be helpful for counties to develop consensus among relevant agencies on an Olmstead-consistent vision of IMD/SH usage.*** Developing a clear standard with accompanying policies will help to ensure that usage of IMD/SHs meets Olmstead standards. In the Olmstead decision the Supreme Court held that institutionalization required a burden of proof on the public system to show why community care is not appropriate. Thus, IMDs should be used only as long as recovery-oriented treatment professionals do not believe any community-based services would be appropriate and after all other less restrictive alternatives have been considered.

2.3 ***Applying a client-directed recovery-based orientation to their use of IMD/SHs would help in creating a consistent systemwide orientation and approach to the use of institutions as short term interventions to be used as a last resort.*** A system-wide recovery orientation and integration of IMDs and community programs and services can provide hope and a consistent approach that can be effective in helping people get out of institutions and be successful in the community. The application of this approach to the use of IMD/SHs will promote both client recovery and appropriate use of IMD/SHs. Giving all clients placed in an IMD/SH the message that the placement is temporary and asking clients from the start where they want to live and what they want to do when they leave the IMD/SH promotes hope and a recovery orientation.

2.4 ***Centralized gate-keeping and monitoring processes are most effective when they have sufficient financial and management support.*** If the centralized units that counties

have developed are to be effective they need to have authority commensurate with their responsibility, have sufficient numbers of well trained clinicians familiar with community resources, and have the ongoing visible support of county DMH leadership. Counties should consider having a quarterly review, with Mental Health Director participation, about issues, policies and resource questions related to IMD utilization, in order to ensure quality improvement of this function consistent with the counties' developed philosophy and policies.

2.5 ***It is important for county departments of mental health to work closely on an ongoing basis with all the constituencies involved with civil commitment policies and procedures.*** Because these practices, particularly those related to conservatorship, have so large an impact on IMD/SH usage all parties need to continually ensure that they are consistent with the overall vision of the county with regard to involuntary placements. Clear responsibility needs to be assigned to consistent on-site monitoring of clients while in IMD/SHs and for facilitating discharge planning with the IMDs.

FINDING 3: QUALITY OF CARE IN IMDs NEEDS IMPROVEMENT

While a formal assessment of the quality of care in IMDs was not a specific goal of the Study, information from county site visits, the client data, and the IMD site visits leads us to this overall finding.

3A: ***A recovery vision and an individualized orientation are not infused in IMD services.*** While the facilities visited were found to abide by licensing requirements to develop a client treatment plan and to review it periodically, treatment goals and treatment programs are often generic with little evidence of real client involvement in charting a treatment course and setting goals, let alone developing a recovery plan. Most IMD programming does not reflect a recovery orientation.

3B: ***Medication practices are less than optimal.*** The major concerns expressed by county staff and reinforced by our findings include the following:

- *Amount of psychiatrist time*. There was a large range in the amount of psychiatrist time on site with practices appearing better in IMDs with greater amounts of on-site psychiatrist time. Counties also varied in their relationship to the treating psychiatrist all the way from employing them, to closely monitoring them according to county established standards of care, to no monitoring at all.

- *Monitoring of psychiatrists.* Medication practices in IMDs appear to be better in counties where there is more active involvement by the county. Examples of this were two of the Study counties, Counties E and B, had established medication policies and communicated them effectively to IMDs.

- *Medication practice for long-stay clients.* More assertive medication approaches would appear to be warranted with clients who are not making

progress on existing regimens in most facilities. Many charts in the Long-Stay Study lacked information about medication history due to periodic "thinning" of charts.

3C: ***Linguistic coverage and some special programs are present in IMDs, but there are few signs of comprehensive cultural competence.*** It is encouraging that some IMDs have specific programs for cultural groups including Southeast Asian/Pacific Islanders and Vietnamese. Also, it appeared that programs had sufficient bilingual staff to ensure that almost all clients had access at all times to staff who spoke their primary language. It was not apparent, however, that the IMD programming for individual clients made any special reference or took account of the potential impact of culture on individual clients. Also, not all IMDs apparently ensure that their staff have regular training in cultural competence.

3D: ***Staff inertia and pessimism are too predominant regarding many long-stay clients.*** About one-third of the clients who had been in an IMD/SH for longer than 18 months were not expected to be discharged at any time in the foreseeable future. While this level of care may be necessary for relatively long periods of time for some clients, it appears that facilities and counties may have "given up" on some clients.

3E: ***County and IMD quality of care initiatives can make a positive difference.*** At least two of the case-study counties employed formal quality improvement initiatives with their IMDs and reported that while it took substantial effort they were pleased with the overall success of the effort.

Recommendations

3.1. ***Counties can undertake quality improvement initiatives with IMDs they use.*** While there is no evidence for what the optimal investment might be in the quality of care in IMDs, we suggest that counties at least consider some of the following options:

- Provide higher reimbursement levels for higher quality of staffing
- Provide more standards for the care delivered
- Provide ongoing staff training for all levels of IMD staff
- Engage in quality reviews of the IMDs
- Require IMDs to teach recovery concepts and illness management information and skills
- Require a minimal level of ongoing cultural competence training

3.2. ***There are some effective steps that can be taken to encourage better medications practices.*** The nature of the IMDs used by each county varies, so it is more appropriate to think in terms of establishing standards rather than insisting on any particular structure.

- Counties can develop reasonable ratios of psychiatric time in the facility to the number of clients in residence.

- The structure of the relationship of the psychiatrist to the county should be such that counties can monitor and assure appropriate, informed and assertive medication practices. Whether psychiatrists are employed on contract with the county or hired or contracted with directly by the IMD, the ability to require adherence to protocols and/or routine monitoring is important.

3.3 ***County annual reviews of the status of their long-stay client to determine what kind of more active treatment is warranted can be critical in assuring appropriate use of institutional resources.*** Reviews of long-stay client's treatment plans could be done periodically to determine what kind of changes are needed in medication regimens and other treatment services. Counties should consider the establishment of special programs, or the augmenting of rates for established programs that have the best available recovery and rehabilitation programming to be used specifically for some of these very long-stay clients. All clients in their long-stay population should be given a chance to succeed in a community placement, even if this means taking some risks.

3.4 ***Pilot program initiated by the state can be helpful in determining the most effective treatment approaches for clients in IMD/SHs.*** The State DMH could pilot alternative programming regimens within IMDs that would be more in keeping with the recovery vision. This could also include testing of alternatives that would waive the 27-hour STP standards in favor of more individualized alternative services. An evaluation of the results of such pilots could be useful to the field and could result in a revision of the existing program requirements for STP and MHRC licensing and certification.[13]

3.5 ***A state sponsored forum to define and develop more specific psychiatric practice standards for IMDs could improve consistency and quality of care across IMDs.*** The quality of psychiatric practices in IMDs is critical for client success. It would be helpful for State DMH to take the initiative to work with counties in establishing standards for the number of hours of psychiatric coverage required in IMDs and the nature of the monitoring that counties should do to ensure appropriate care.

FINDING 4: IMPROVED COMMUNITY RESOURCES WILL ALLOW FOR MORE APPROPRIATE USE OF IMD/SHS

All interviewed county staff noted that they could reduce the use of IMD/SHs if they had additional community resources.

4A. ***Lack of adequate housing resources and intensive case management in the community were cited as the major obstacles in transitioning clients out of IMDs back into the community.*** The most important ingredients in enabling someone to return to the community from an IMD are appropriate housing and sufficient support services. These can be and are made available in a variety of structures in different counties as we have noted in the report. Ideally, someone should be able to return to an appropriate *permanent*

[13] Attention may also need to be given to altering other STP, SNF, or MHRC regulations because such a recovery orientation may require facilities to take a greater level of risk with clients which they will be reluctant to do if they are too severely penalized by licensing agencies.

living situation, where they can remain as long as they choose while supports would be made flexibly available 24/7 to the extent necessary.

4B. ***Counties have reduced IMD/SH usage through the development of specific combinations of housing-support services.*** In the absence of a full range of supportive housing options, counties are also using a range of augmented community facilities that provide "step-down" programs, which combine housing and treatment services and which serve as *temporary* housing. Additionally they use intensive case management, ACT-like and integrated service agency programs to structure support services to augment other types of housing such as B/C, apartments, room and board, etc. Specific targeted strategies by County D to use an ACT program and County E to use step-down residential programs have shown success in reducing IMD usage.

4C. ***While more housing and case management resources are needed, coordination and integration of the available and existing resources can ensure a county's appropriate use of IMDs.*** The Tracking Study forms asked every three months whether the client still in the IMD/SH could be placed in the community if an appropriate program or setting were available and if the program or setting, if it already existed, would take the client. It was apparent from the answers that the IMD staff/county monitors did not think in these terms. It is difficult to prepare clients for community living when the staff is not thinking in terms of what it takes to succeed in varying community settings.

Some counties have policies which require or encourage community care case managers to follow their clients while they are in an IMD and/or which assign clients to community case managers prior to their discharge from the IMD. But constrained community resources sometimes results in these policies not being fully implemented.

4D. ***B/C facilities are not sufficiently funded nor supported (by counties nor licensing agencies) to play the role they are forced to currently play in the system of care.*** Despite the fact that there may be better alternatives in the long run, counties are heavily dependent on B/C facilities as discharge options from IMDs, yet B/C rates lag behind those for the developmentally disabled, resulting in a decrease in bed availability, and county staff are almost uniformly concerned about the quality of care in B/C homes. Additionally, Community Care Licensing (CCL) faces major challenges in understanding services for clients with mental illness in the community, and county staff and facilities consistently report frustrations and problems with licensing staff and regulations.

4E. ***Families are an important resource for many clients.*** A number of clients in the Study counties were living with their families prior to going into an IMD, and many returned to families upon discharge. While many clients have no family living near and others do not want their families involved, families can be important components of clients' social networks and are important to clients' recovery.

Recommendations

4.1. ***The development of additional flexible supportive housing resources at both the state and county levels is critical in reducing IMD utilization.*** Because a supportive housing model is considered a best practice for adults with serious mental illness, this should receive the first priority for funding. State support for the establishment of additional supported housing programs helps counties in expanding their available housing resources.

4.2. ***ACT-type teams and integrated service agencies can be used as helpful alternative resources for returning long-stay IMD/SH clients to the community.*** ACT-type teams and integrated service agencies have demonstrated effectiveness in serving as alternatives for clients who are long-term residents of IMD/SHs. Such teams can be funded either with MHSA Full Service Partnership (FSP) dollars or with the savings that result from reduced IMD/SH utilization.

4.3 ***Intensive case management services help clients to be more successful in their transition to the community.*** It would be beneficial for intensive service teams and intensive case management programs to maintain contact with any of their clients who are admitted to an IMD to reinforce the temporary nature of the placement and to ensure a more effective transition back to the community. Additionally, assigning all IMD discharges, at least in the short-term, to an intensive service/case management team, if they do not already have such a connection, would help to ensure an effective transition to the community.

4.4. ***Counties may want to consider the development of a range of augmented residential programs.*** While not all agree that such temporary programs are a worthwhile direction for the system as a whole, some counties have found such facilities useful as "step-down" programs in reducing lengths of stay in IMDs and diverting some IMD admissions. These facilities may be particularly helpful in achieving immediate reductions in IMD utilization while a county is building its more permanent supportive housing stock.

4.5 ***Implementing more effective discharge planning processes can reduce lengths of stay and recidivism.*** The lack of an IMD incentive to discharge clients and the large caseloads of county and Public Guardian monitors are obstacles to quick and effective discharge planning. Counties may want to consider creating teams comprised of IMD staff, long-term care staff, the Public Guardian and community program staff who will begin to work with clients on transition out of IMDs as soon as they are placed into the facilities. To be effective these teams will need to have thorough and current knowledge of both the clients and the community resources.

4.6 ***Counties who must rely significantly on B/C facilities for the near future could attempt to enhance quality of life and recovery opportunities for residents in such facilities.*** Again, while not ideal, many counties may be reliant on B/C facilities for some time in the future. A few of the Study counties struggled with developing an appropriate rate augmentation system for selected facilities and/or clients. Counties may want to

collaborate on the development of more effective strategies for enhancing the living environment for clients in such facilities.

4.7 ***A collaborative effort initiated by DMH with CCL would help to promote the appropriate use of community care facilities for clients with serious psychiatric disabilities.*** Many facilities in our Study counties expressed concerns about working with clients with serious mental illness because of a fear of licensing problems and sanctions. State DMH and CCL could work together to adopt policies and practices in working with facilities that serve clients with severe mental illness that are more in keeping with what is known about best practices and a recovery oriented approach.

4.8 ***Counties may want to consider developing support programs to assist families who provide housing and other support to their family member with mental illness.*** The fact that many clients are living with families at the time of the episode that leads to IMD placement suggests that the provision of special assistance to families prior to and during times of crisis might forestall the path towards acute care followed by an IMD admission. A demonstration project of such an intervention might be worthwhile. Counties could also encourage IMDs to enhance as much as possible appropriate family involvement while their family member is at the IMD. Additionally, as counties continue to reduce the availability of IMD/SH beds they need to be cognizant of family concerns that these resources not become too scarce.

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[i] The state data was obtained from the DMH and is based on CDS and CSI. For the Phase I Report we compared the information the Study Team obtained from the county interviews with the information in these state data bases and we unable to explain some major discrepancies. We therefore use the state data here only to make general points about trends since the data may not be completely accurate. There is also significant amounts of missing data at the state level; we estimate that at least 18% of the data is missing. We received the final set of date in May 2005. A number of counties that usually reported IMD data had not yet reported their information for FY 03-04 so we did not use the data for that year. The final year of reported data used in the report is thus FY 02-03.

[ii] Overall, 37% of the clients had an Axis III condition noted by staff on the Intake form. Two-thirds of these had one medical condition listed, 18.5% had two, 14% had three and 1% had four.

[iii] Conservatorship figures for FY 99-00 from state DMH, Statistics and Data Analysis Section. Number of SSI Disability Recipients for September 2002 from CDSS, Research and Development Division.

[iv] County E had by far the shortest length of stay in acute care (mean of 16 days and 64% discharged within two weeks). It is possible that the greater need for acute care results from clients being less stabilized at the time of admission to the IMD. This interpretation, however, is called into question by the functional status scores of County E clients at admission – which were generally higher than average and the percentage with violence to self or others which were lower than average.

[v] The length of time of the study period varied by county depending on how long it took them to enroll the agreed upon number of clients into the Tracking Study. The following shows the mean and median lengths of time for the clients remaining in the IMD/SH at the end of the Study.

Length of Time (in months) Between Enrollment and Final Status for Clients Still in IMD/SH

	County A (N=8)	County B (N=65)	County C (N=15)	County D (N=7)	County E (N=18)	*Total (N=113)*
Mean	10.8	10.9	13.1	12.8	13.2	*11.3*

Median	10.5	11.3	12.4	13.2	13.1	*11.7*